



UHID	3022251	Date	24/12/2022
Name	Mrs. Sangeeta Gor	Sex	Female Age 57
OPD	Pap Smear	Health Check Up	

57y / P14

Drug allergy:
Sys illness:

PM: 52yrs of age

No h/o PMB

- Pt's last pap smear in 2021

- ~~Pt says~~

Pap - ex/ug (P) pap

Adv

- Au c reports

- Pap smear yearly

- mammography 1 yr
w/ G Pelvis 1 yr

- self breast exam

haha



UHID	3022251	Date	24/12/2022
Name	Mrs. Sangeeta Gor	Sex	Female Age 57
OPD	Ophthal 14	Health Check Up	

Ch. No

Drug allergy: → Not known
 Sys illness: → No

HC No

Unid V → RE → 6/12P
 → LE → 6/18P

Ref → Ra -1.00 / -1.25 x 90° 6/6
 → Cr -1.00 / -0.75 x 90° 6/6

Add → +2.50 → No

I.O.A. → R → 13.6
 → L → 13.4 (Same as P.U.P.)

[Handwritten Signature]



UHID	3022251	Date	24/12/2022
Name	Mrs. Sangeeta Gor	Sex	Female Age 57
OPD	Dental 12	Health Check Up	

Drug allergy:
 Sys illness:

Pt is having PMP disease & is on steroids,
anti-hypertensives & homeopathy medicat^{ns}.

O/E: 1) G.D $\frac{76}{6}$

2) Decayed $\frac{87}{8}$

Adv: 1) Ext $\frac{76}{6}$

2) OPG - Full mouth

BHI



Cert. No. MC-2275

LABORATORY REPORT

PATIENT NAME : MRS.SANGEETA GOR



PATIENT ID : FH.3022251

CLIENT PATIENT ID : UID:3022251

ACCESSION NO : 0022VL005357

AGE : 57 Years

SEX : Female

ABHA NO :

DRAWN : 24/12/2022 09:10:00

RECEIVED : 24/12/2022 09:10:22

REPORTED : 24/12/2022 13:52:57

CLIENT NAME : FORTIS VASHI-CHC -SPLZD

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:3022251 REQNO-1349081

CORP-OPD

BILLNO-150122OPCR066018

BILLNO-150122OPCR066018

Test Report Status	Final	Results	Biological Reference Interval	Units
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KIDNEY PANEL - 1

BLOOD UREA NITROGEN (BUN), SERUM

BLOOD UREA NITROGEN

8

6 - 20

mg/dL

METHOD : UREASE - UV

CREATININE EGFR- EPI

CREATININE

0.67

0.60 - 1.10

mg/dL

METHOD : ALKALINE PICRATE KINETIC JAFFES

AGE

57

years

GLOMERULAR FILTRATION RATE (FEMALE)

101.88

Refer Interpretation Below

mL/min/1.73

METHOD : CALCULATED PARAMETER

BUN/CREAT RATIO

BUN/CREAT RATIO

11.94

5.00 - 15.00

METHOD : CALCULATED PARAMETER

URIC ACID, SERUM

URIC ACID

4.7

2.6 - 6.0

mg/dL

METHOD : URICASE UV

TOTAL PROTEIN, SERUM

TOTAL PROTEIN

7.5

6.4 - 8.2

g/dL

METHOD : BIURET

ALBUMIN, SERUM

ALBUMIN

3.7

3.4 - 5.0

g/dL

METHOD : BCP DYE BINDING

GLOBULIN

GLOBULIN

3.8

2.0 - 4.1

g/dL

METHOD : CALCULATED PARAMETER

ELECTROLYTES (NA/K/CL), SERUM

SODIUM, SERUM

138

136 - 145

mmol/L

METHOD : ISE INDIRECT

POTASSIUM, SERUM

4.40

3.50 - 5.10

mmol/L

METHOD : ISE INDIRECT

CHLORIDE, SERUM

102

98 - 107

mmol/L

METHOD : ISE INDIRECT

Interpretation(s)

PHYSICAL EXAMINATION, URINE

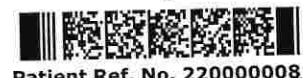
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BILLNO-150122OPCR066018
BILLNO-150122OPCR066018

Test Report Status	Final	Results	Biological Reference Interval	Units
COLOR		PALE YELLOW		
METHOD : PHYSICAL				
APPEARANCE		CLEAR		
METHOD : VISUAL				
CHEMICAL EXAMINATION, URINE				
PH		6.5	4.7 - 7.5	
METHOD : REFLECTANCE SPECTROPHOTOMETRY- DOUBLE INDICATOR METHOD				
SPECIFIC GRAVITY		<=1.005	1.003 - 1.035	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (APPARENT PKA CHANGE OF PRETREATED POLYELECTROLYTES IN RELATION TO IONIC CONCENTRATION)				
PROTEIN		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY - PROTEIN-ERROR-OF-INDICATOR PRINCIPLE				
GLUCOSE		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DOUBLE SEQUENTIAL ENZYME REACTION-GOD/POD				
KETONES		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ROTHERA'S PRINCIPLE				
BLOOD		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, PEROXIDASE LIKE ACTIVITY OF HAEMOGLOBIN				
BILIRUBIN		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, DIAZOTIZATION- COUPLING OF BILIRUBIN WITH DIAZOTIZED SALT				
UROBILINOGEN		NORMAL	NORMAL	
METHOD : REFLECTANCE SPECTROPHOTOMETRY (MODIFIED EHRlich REACTION)				
NITRITE		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, CONVERSION OF NITRATE TO NITRITE				
LEUKOCYTE ESTERASE		NOT DETECTED	NOT DETECTED	
METHOD : REFLECTANCE SPECTROPHOTOMETRY, ESTERASE HYDROLYSIS ACTIVITY				
MICROSCOPIC EXAMINATION, URINE				
RED BLOOD CELLS		NOT DETECTED	NOT DETECTED	/HPF
METHOD : MICROSCOPIC EXAMINATION				
PUS CELL (WBC'S)		1-2	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
EPITHELIAL CELLS		0-1	0-5	/HPF
METHOD : MICROSCOPIC EXAMINATION				
CASTS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				
CRYSTALS		NOT DETECTED		
METHOD : MICROSCOPIC EXAMINATION				

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PATIENT ID : **FH.3022251**

CLIENT PATIENT ID : UID:3022251

ACCESSION NO : **0022VL005357**

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BACTERIA

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

YEAST

NOT DETECTED

NOT DETECTED

METHOD : MICROSCOPIC EXAMINATION

REMARKS

URINARY MICROSCOPIC EXAMINATION DONE ON URINARY CENTRIFUGED SEDIMENT.

Interpretation(s)

Interpretation(s)

BLOOD UREA NITROGEN (BUN), SERUM-Causes of Increased levels include Pre renal (High protein diet, Increased protein catabolism, GI haemorrhage, Cortisol, Dehydration, CHF Renal), Renal Failure, Post Renal (Malignancy, Nephrolithiasis, Prostatism)
Causes of decreased level include Liver disease, SIADH.

CREATININE EGFR- EPI-

GFR- Glomerular filtration rate (GFR) is a measure of the function of the kidneys. The GFR is a calculation based on a serum creatinine test. Creatinine is a muscle waste product that is filtered from the blood by the kidneys and excreted into urine at a relatively steady rate. When kidney function decreases, less creatinine is excreted and concentrations increase in the blood. With the creatinine test, a reasonable estimate of the actual GFR can be determined.

A GFR of 60 or higher is in the normal range.

A GFR below 60 may mean kidney disease.

A GFR of 15 or lower may mean kidney failure.

Estimated GFR (eGFR) is the preferred method for identifying people with chronic kidney disease (CKD). In adults, eGFR calculated using the Modification of Diet in Renal Disease (MDRD) Study equation provides a more clinically useful measure of kidney function than serum creatinine alone.

The CKD-EPI creatinine equation is based on the same four variables as the MDRD Study equation, but uses a 2-slope spline to model the relationship between estimated GFR and serum creatinine, and a different relationship for age, sex and race. The equation was reported to perform better and with less bias than the MDRD Study equation, especially in patients with higher GFR. This results in reduced misclassification of CKD.

The CKD-EPI creatinine equation has not been validated in children & will only be reported for patients = 18 years of age. For pediatric and childrens, Schwartz Pediatric Bedside eGFR (2009) formulae is used. This revised "bedside" pediatric eGFR requires only serum creatinine and height.

URIC ACID, SERUM-Causes of Increased levels:-Dietary(High Protein Intake,Prolonged Fasting,Rapid weight loss),Gout,Lesch nyhan syndrome,Type 2 DM,Metabolic syndrome

Causes of decreased levels-Low Zinc intake,OCP,Multiple Sclerosis

TOTAL PROTEIN, SERUM-Serum total protein,also known as total protein, is a biochemical test for measuring the total amount of protein in serum..Protein in the plasma is made up of albumin and globulin

Higher-than-normal levels may be due to: Chronic inflammation or infection, including HIV and hepatitis B or C, Multiple myeloma, Waldenstrom's disease
Lower-than-normal levels may be due to: Agammaglobulinemia, Bleeding (hemorrhage), Burns,Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome,Protein-losing enteropathy etc.

ALBUMIN, SERUM-

Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance,malnutrition and wasting etc.

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HAEMATOLOGY - CBC

CBC-5, EDTA WHOLE BLOOD

BLOOD COUNTS, EDTA WHOLE BLOOD

HEMOGLOBIN (HB)	14.3	12.0 - 15.0	g/dL
METHOD : SPECTROPHOTOMETRY			
RED BLOOD CELL (RBC) COUNT	5.05	High 3.8 - 4.8	mil/ μ L
METHOD : ELECTRICAL IMPEDANCE			
WHITE BLOOD CELL (WBC) COUNT	8.85	4.0 - 10.0	thou/ μ L
METHOD : DOUBLE HYDRODYNAMIC SEQUENTIAL SYSTEM(DHSS)CYTOMETRY			
PLATELET COUNT	330	150 - 410	thou/ μ L
METHOD : ELECTRICAL IMPEDANCE			

RBC AND PLATELET INDICES

HEMATOCRIT (PCV)	42.0	36 - 46	%
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR VOLUME (MCV)	83.1	83 - 101	fL
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN (MCH)	28.3	27.0 - 32.0	pg
METHOD : CALCULATED PARAMETER			
MEAN CORPUSCULAR HEMOGLOBIN CONCENTRATION(MCHC)	34.0	31.5 - 34.5	g/dL
METHOD : CALCULATED PARAMETER			
RED CELL DISTRIBUTION WIDTH (RDW)	14.4	High 11.6 - 14.0	%
METHOD : CALCULATED PARAMETER			
MENTZER INDEX	16.5		
MEAN PLATELET VOLUME (MPV)	8.5	6.8 - 10.9	fL
METHOD : CALCULATED PARAMETER			

WBC DIFFERENTIAL COUNT

NEUTROPHILS	57	40 - 80	%
METHOD : FLOW CYTOMETRY			
LYMPHOCYTES	34	20 - 40	%
METHOD : FLOW CYTOMETRY			
MONOCYTES	7	2 - 10	%
METHOD : FLOW CYTOMETRY			
EOSINOPHILS	2	1 - 6	%
METHOD : FLOW CYTOMETRY			

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CLINICAL INFORMATION :
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CORP-OPD
BILLNO-1501220PCR066018
BILLNO-1501220PCR066018

Test Report Status	Final	Results	Biological Reference Interval
BASOPHILS		00	0 - 2 %
METHOD : FLOW CYTOMETRY			
ABSOLUTE NEUTROPHIL COUNT		5.04	2.0 - 7.0 thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE LYMPHOCYTE COUNT		3.01	High 1.0 - 3.0 thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE MONOCYTE COUNT		0.62	0.2 - 1.0 thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE EOSINOPHIL COUNT		0.18	0.02 - 0.50 thou/ μ L
METHOD : CALCULATED PARAMETER			
ABSOLUTE BASOPHIL COUNT		0	Low 0.02 - 0.10 thou/ μ L
METHOD : CALCULATED PARAMETER			
NEUTROPHIL LYMPHOCYTE RATIO (NLR)		1.7	
METHOD : CALCULATED PARAMETER			
MORPHOLOGY			
RBC		PREDOMINANTLY NORMOCYTIC NORMOCHROMIC	
METHOD : MICROSCOPIC EXAMINATION			
WBC		NORMAL MORPHOLOGY	
METHOD : MICROSCOPIC EXAMINATION			
PLATELETS		ADEQUATE	
METHOD : MICROSCOPIC EXAMINATION			

Interpretation(s)

RBC AND PLATELET INDICES-Mentzer index (MCV/RBC) is an automated cell-counter based calculated screen tool to differentiate cases of Iron deficiency anaemia(>13) from Beta thalassaemia trait (<13) in patients with microcytic anaemia. This needs to be interpreted in line with clinical correlation and suspicion. Estimation of HbA2 remains the gold standard for diagnosing a case of beta thalassaemia trait.
WBC DIFFERENTIAL COUNT-The optimal threshold of 3.3 for NLR showed a prognostic possibility of clinical symptoms to change from mild to severe in COVID positive patients. When age = 49.5 years old and NLR = 3.3, 46.1% COVID-19 patients with mild disease might become severe. By contrast, when age < 49.5 years old and NLR 3.3, COVID-19 patients tend to show mild disease.
(Reference to - The diagnostic and predictive role of NLR, d-NLR and PLR in COVID-19 patients ; A.-P. Yang, et al.; International Immunopharmacology 84 (2020) 10651
This ratio element is a calculated parameter and out of NABL scope.

HAEMATOLOGY

ERYTHROCYTE SEDIMENTATION RATE (ESR), WHOLE BLOOD

E.S.R 30 High 0 - 20 mm at 1 hr
METHOD : WESTERGREN METHOD

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PATIENT ID : **FH.3022251** CLIENT PATIENT ID : UID:3022251
ACCESSION NO : **0022VL005357** AGE : 57 Years SEX : Female ABHA NO :
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CLINICAL INFORMATION :

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CORP-OPD
BILLNO-150122OPCR066018
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Test Report Status	Final	Results	Biological Reference Interval
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Interpretation(s)

ERYTHROCYTE SEDIMENTATION RATE (ESR),WHOLE BLOOD-TEST DESCRIPTION :-
Erythrocyte sedimentation rate (ESR) is a test that indirectly measures the degree of inflammation present in the body. The test actually measures the rate of fall (sedimentation) of erythrocytes in a sample of blood that has been placed into a tall, thin, vertical tube. Results are reported as the millimetres of clear fluid (plasma) that are present at the top portion of the tube after one hour. Nowadays fully automated instruments are available to measure ESR.

ESR is not diagnostic; it is a non-specific test that may be elevated in a number of different conditions. It provides general information about the presence of an inflammatory condition. CRP is superior to ESR because it is more sensitive and reflects a more rapid change.

TEST INTERPRETATION

Increase in: Infections, Vasculitides, Inflammatory arthritis, Renal disease, Anemia, Malignancies and plasma cell dyscrasias, Acute allergy Tissue injury, Pregnancy, Estrogen medication, Aging.

Finding a very accelerated ESR(>100 mm/hour) in patients with ill-defined symptoms directs the physician to search for a systemic disease (Paraproteinemias, Disseminated malignancies, connective tissue disease, severe infections such as bacterial endocarditis).

In pregnancy BRI in first trimester is 0-48 mm/hr(62 if anemic) and in second trimester (0-70 mm /hr(95 if anemic). ESR returns to normal 4th week post partum.

Decreased in: Polycythemia vera, Sickle cell anemia

LIMITATIONS

False elevated ESR : Increased fibrinogen, Drugs(Vitamin A, Dextran etc), Hypercholesterolemia

False Decreased : Poikilocytosis,(SickleCells,spherocytes),Microcytosis, Low fibrinogen, Very high WBC counts, Drugs(Quinine, salicylates)

REFERENCE :

1. Nathan and Oski's Haematology of Infancy and Childhood, 5th edition; 2. Paediatric reference intervals. AACC Press, 7th edition. Edited by S. Soldin; 3. The reference for the adult reference range is "Practical Haematology by Dacie and Lewis, 10th edition.

IMMUNOHAEMATOLOGY

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD

ABO GROUP TYPE O
METHOD : TUBE AGGLUTINATION
RH TYPE POSITIVE
METHOD : TUBE AGGLUTINATION

Interpretation(s)

ABO GROUP & RH TYPE, EDTA WHOLE BLOOD-

Blood group is identified by antigens and antibodies present in the blood. Antigens are protein molecules found on the surface of red blood cells. Antibodies are found in plasma. To determine blood group, red cells are mixed with different antibody solutions to give A,B,O or AB.

Disclaimer: "Please note, as the results of previous ABO and Rh group (Blood Group) for pregnant women are not available, please check with the patient records for availability of the same."

The test is performed by both forward as well as reverse grouping methods.

BIOCHEMISTRY

LIVER FUNCTION PROFILE, SERUM

BILIRUBIN, TOTAL 0.52 0.2 - 1.0 mg/dL
METHOD : JENDRASSIK AND GROFF
BILIRUBIN, DIRECT 0.12 0.0 - 0.2 mg/dL
METHOD : JENDRASSIK AND GROFF

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BILIRUBIN, INDIRECT		0.40	0.1 - 1.0 mg/dL
METHOD : CALCULATED PARAMETER			
TOTAL PROTEIN		7.5	6.4 - 8.2 g/dL
METHOD : BIURET			
ALBUMIN		3.7	3.4 - 5.0 g/dL
METHOD : BCP DYE BINDING			
GLOBULIN		3.8	2.0 - 4.1 g/dL
METHOD : CALCULATED PARAMETER			
ALBUMIN/GLOBULIN RATIO		1.0	1.0 - 2.1 RATIO
METHOD : CALCULATED PARAMETER			
ASPARTATE AMINOTRANSFERASE (AST/SGOT)		19	15 - 37 U/L
METHOD : UV WITH P5P			
ALANINE AMINOTRANSFERASE (ALT/SGPT)		28	< 34.0 U/L
METHOD : UV WITH P5P			
ALKALINE PHOSPHATASE		101	30 - 120 U/L
METHOD : PNPP-ANP			
GAMMA GLUTAMYL TRANSFERASE (GGT)		19	5 - 55 U/L
METHOD : GAMMA GLUTAMYL CARBOXY 4-NITROANILIDE			
LACTATE DEHYDROGENASE		210	High 100 - 190 U/L
METHOD : LACTATE -PYRUVATE			
GLUCOSE FASTING, FLUORIDE PLASMA			
FBS (FASTING BLOOD SUGAR)		97	74 - 99 mg/dL
METHOD : HEXOKINASE			
GLYCOSYLATED HEMOGLOBIN(HBA1C), EDTA WHOLE BLOOD			
HBA1C		5.9	High Non-diabetic: < 5.7 Pre-diabetics: 5.7 - 6.4 Diabetics: > or = 6.5 Therapeutic goals: < 7.0 Action suggested : > 8.0 (ADA Guideline 2021) %
METHOD : HB VARIANT (HPLC)			
ESTIMATED AVERAGE GLUCOSE(EAG)		122.6	High < 116.0 mg/dL
METHOD : CALCULATED PARAMETER			

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Patient Ref. No. 220000008



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Table with 3 columns: Test Report Status (Final), Results, Biological Reference Interval

Interpretation(s)

LIVER FUNCTION PROFILE, SERUM- LIVER FUNCTION PROFILE

Bilirubin is a yellowish pigment found in bile and is a breakdown product of normal heme catabolism. Bilirubin is excreted in bile and urine, and elevated levels may give yellow discoloration in jaundice. Elevated levels result from increased bilirubin production (eg, hemolysis and ineffective erythropoiesis), decreased bilirubin excretion (eg, obstruction and hepatitis), and abnormal bilirubin metabolism (eg, hereditary and neonatal jaundice). Conjugated (direct) bilirubin is elevated more than unconjugated (indirect) bilirubin in Viral hepatitis, Drug reactions, Alcoholic liver disease. Conjugated (direct) bilirubin is also elevated more than unconjugated (indirect) bilirubin when there is some kind of blockage of the bile ducts like in Gallstones getting into the bile ducts, tumors & Scarring of the bile ducts. Increased unconjugated (indirect) bilirubin may be a result of Hemolytic or pernicious anemia, Transfusion reaction & a common metabolic condition termed Gilbert syndrome, due to low levels of the enzyme that attaches sugar molecules to bilirubin.

AST is an enzyme found in various parts of the body. AST is found in the liver, heart, skeletal muscle, kidneys, brain, and red blood cells, and it is commonly measured clinically as a marker for liver health. AST levels increase during chronic viral hepatitis, blockage of the bile duct, cirrhosis of the liver, liver cancer, kidney failure, hemolytic anemia, pancreatitis, hemochromatosis. AST levels may also increase after a heart attack or strenuous activity. ALT test measures the amount of this enzyme in the blood. ALT is found mainly in the liver, but also in smaller amounts in the kidneys, heart, muscles, and pancreas. It is commonly measured as a part of a diagnostic evaluation of hepatocellular injury, to determine liver health. AST levels increase during acute hepatitis, sometimes due to a viral infection, ischemia to the liver, chronic hepatitis, obstruction of bile ducts, cirrhosis.

ALP is a protein found in almost all body tissues. Tissues with higher amounts of ALP include the liver, bile ducts and bone. Elevated ALP levels are seen in Biliary obstruction, Osteoblastic bone tumors, osteomalacia, hepatitis, Hyperparathyroidism, Leukemia, Lymphoma, Paget's disease, Rickets, Sarcoidosis etc. Lower-than-normal ALP levels seen in Hypophosphatasia, Malnutrition, Protein deficiency, Wilson's disease. GGT is an enzyme found in cell membranes of many tissues mainly in the liver, kidney and pancreas. It is also found in other tissues including intestine, spleen, heart, brain and seminal vesicles. The highest concentration is in the kidney, but the liver is considered the source of normal enzyme activity. Serum GGT has been widely used as an index of liver dysfunction. Elevated serum GGT activity can be found in diseases of the liver, biliary system and pancreas. Conditions that increase serum GGT are obstructive liver disease, high alcohol consumption and use of enzyme-inducing drugs etc. Serum total protein, also known as total protein, is a biochemical test for measuring the total amount of protein in serum. Protein in the plasma is made up of albumin and globulin. Higher-than-normal Agammaglobulinemia, Bleeding (hemorrhage), Burns, Glomerulonephritis, Liver disease, Malabsorption, Malnutrition, Nephrotic syndrome, Protein-losing enteropathy etc. Human serum albumin is the most abundant protein in human blood plasma. It is produced in the liver. Albumin constitutes about half of the blood serum protein. Low blood albumin levels (hypoalbuminemia) can be caused by: Liver disease like cirrhosis of the liver, nephrotic syndrome, protein-losing enteropathy, Burns, hemodilution, increased vascular permeability or decreased lymphatic clearance, malnutrition and wasting etc.

GLUCOSE FASTING, FLUORIDE PLASMA-TEST DESCRIPTION

Normally, the glucose concentration in extracellular fluid is closely regulated so that a source of energy is readily available to tissues and so that no glucose is excreted in the urine.

Increased in

Diabetes mellitus, Cushing's syndrome (10 - 15%), chronic pancreatitis (30%). Drugs: corticosteroids, phenytoin, estrogen, thiazides.

Decreased in

Pancreatic islet cell disease with increased insulin, insulinoma, adrenocortical insufficiency, hypopituitarism, diffuse liver disease, malignancy (adrenocortical, stomach, fibrosarcoma), infant of a diabetic mother, enzyme deficiency diseases (e.g., galactosemia), Drugs- insulin, ethanol, propranolol; sulfonyleureas, tolbutamide, and other oral hypoglycemic agents.

NOTE:

While random serum glucose levels correlate with home glucose monitoring results (weekly mean capillary glucose values), there is wide fluctuation within individuals. Thus, glycosylated hemoglobin (HbA1c) levels are favored to monitor glycemic control.

High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.

GLYCOSYLATED HEMOGLOBIN (HbA1C), EDTA WHOLE BLOOD-Used For:

- 1. Evaluating the long-term control of blood glucose concentrations in diabetic patients.
2. Diagnosing diabetes.
3. Identifying patients at increased risk for diabetes (prediabetes).

The ADA recommends measurement of HbA1c (typically 3-4 times per year for type 1 and poorly controlled type 2 diabetic patients, and 2 times per year for well-controlled type 2 diabetic patients) to determine whether a patient's metabolic control has remained continuously within the target range.

- 1. eAG (Estimated average glucose) converts percentage HbA1c to mg/dl, to compare blood glucose levels.
2. eAG gives an evaluation of blood glucose levels for the last couple of months.
3. eAG is calculated as eAG (mg/dl) = 28.7 * HbA1c - 46.7

HbA1c Estimation can get affected due to :

- I. Shortened Erythrocyte survival : Any condition that shortens erythrocyte survival or decreases mean erythrocyte age (e.g. recovery from acute blood loss, hemolytic anemia) will falsely lower HbA1c test results. Fructosamine is recommended in these patients which indicates diabetes control over 15 days.
II. Vitamin C & E are reported to falsely lower test results. (possibly by inhibiting glycation of hemoglobin.
III. Iron deficiency anemia is reported to increase test results. Hypertriglyceridemia, uremia, hyperbilirubinemia, chronic alcoholism, chronic ingestion of salicylates & opiates addition are reported to interfere with some assay methods, falsely increasing results.
IV. Interference of hemoglobinopathies in HbA1c estimation is seen in
a. Homozygous hemoglobinopathy. Fructosamine is recommended for testing of HbA1c.
b. Heterozygous state detected (D10 is corrected for HbS & HbC trait.)
c. HbF > 25% on alternate platform (Boronate affinity chromatography) is recommended for testing of HbA1c. Abnormal Hemoglobin electrophoresis (HPLC method) is recommended for detecting a hemoglobinopathy

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Cert. No. MC-2275

LABORATORY REPORT

PATIENT NAME : MRS.SANGEETA GOR



PATIENT ID : FH.3022251

CLIENT PATIENT ID : UID:3022251

ACCESSION NO : 0022VL005357

AGE : 57 Years SEX : Female

ABHA NO :

DRAWN : 24/12/2022 09:10:00

RECEIVED : 24/12/2022 09:10:22

REPORTED : 24/12/2022 13:52:57

CLIENT NAME : FORTIS VASHI-CHC -SPLZD

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:3022251 REQNO-1349081
CORP-OPD
BILLNO-150122OPCR066018
BILLNO-150122OPCR066018

Table with 3 columns: Test Report Status (Final), Results, Biological Reference Interval

BIOCHEMISTRY- LIPID

LIPID PROFILE, SERUM

Main table listing lipid profile results: CHOLESTEROL, TOTAL (212 mg/dL), TRIGLYCERIDES (80 mg/dL), HDL CHOLESTEROL (78 mg/dL), LDL CHOLESTEROL, DIRECT (130 mg/dL), NON HDL CHOLESTEROL (134 mg/dL), CHOL/HDL RATIO (2.7), LDL/HDL RATIO (1.7), VERY LOW DENSITY LIPOPROTEIN (16.0 mg/dL). Includes method descriptions and reference intervals.

Interpretation(s)

LIPID PROFILE, SERUM-Serum cholesterol is a blood test that can provide valuable information for the risk of coronary artery disease. This test can help determine your risk of the build up of plaques in your arteries that can lead to narrowed or blocked arteries throughout your body (atherosclerosis). High cholesterol levels usually don't cause any signs or symptoms, so a cholesterol test is an important tool. High cholesterol levels often are a significant risk factor for heart disease and

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Cert. No. MC-2275

LABORATORY REPORT
PATIENT NAME : MRS.SANGEETA GOR



PATIENT ID : **FH.3022251** CLIENT PATIENT ID : UID:3022251
ACCESSION NO : **0022VL005357** AGE : 57 Years SEX : Female ABHA NO :
DRAWN : 24/12/2022 09:10:00 RECEIVED : 24/12/2022 09:10:22 REPORTED : 24/12/2022 13:52:57
CLIENT NAME : **FORTIS VASHI-CHC -SPLZD** REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:3022251 REQNO-1349081
CORP-OPD
BILLNO-150122OPCR066018
BILLNO-150122OPCR066018

Test Report Status Final Results Biological Reference Interval

important for diagnosis of hyperlipoproteinemia, atherosclerosis, hepatic and thyroid diseases.

Serum Triglyceride are a type of fat in the blood. When you eat, your body converts any calories it doesn't need into triglycerides, which are stored in fat cells. High triglyceride levels are associated with several factors, including being overweight, eating too many sweets or drinking too much alcohol, smoking, being sedentary, or having diabetes with elevated blood sugar levels. Analysis has proven useful in the diagnosis and treatment of patients with diabetes mellitus, nephrosis, liver obstruction, other diseases involving lipid metabolism, and various endocrine disorders. In conjunction with high density lipoprotein and total serum cholesterol, a triglyceride determination provides valuable information for the assessment of coronary heart disease risk. It is done in fasting state.

High-density lipoprotein (HDL) cholesterol. This is sometimes called the "good" cholesterol because it helps carry away LDL cholesterol, thus keeping arteries open and blood flowing more freely. HDL cholesterol is inversely related to the risk for cardiovascular disease. It increases following regular exercise, moderate alcohol consumption and with oral estrogen therapy. Decreased levels are associated with obesity, stress, cigarette smoking and diabetes mellitus.

SERUM LDL The small dense LDL test can be used to determine cardiovascular risk in individuals with metabolic syndrome or established/progressing coronary artery disease, individuals with triglyceride levels between 70 and 140 mg/dL, as well as individuals with a diet high in trans-fat or carbohydrates. Elevated sdLDL levels are associated with metabolic syndrome and an 'atherogenic lipoprotein profile', and are a strong, independent predictor of cardiovascular disease. Elevated levels of LDL arise from multiple sources. A major factor is sedentary lifestyle with a diet high in saturated fat. Insulin-resistance and pre-diabetes have also been implicated, as has genetic predisposition. Measurement of sdLDL allows the clinician to get a more comprehensive picture of lipid risk factors and tailor treatment accordingly. Reducing LDL levels will reduce the risk of CVD and MI.

Non HDL Cholesterol - Adult treatment panel ATP III suggested the addition of Non-HDL Cholesterol as an indicator of all atherogenic lipoproteins (mainly LDL and VLDL). NICE guidelines recommend Non-HDL Cholesterol measurement before initiating lipid lowering therapy. It has also been shown to be a better marker of risk in both primary and secondary prevention studies.

Recommendations:

Results of Lipids should always be interpreted in conjunction with the patient's medical history, clinical presentation and other findings.

NON FASTING LIPID PROFILE includes Total Cholesterol, HDL Cholesterol and calculated non-HDL Cholesterol. It does not include triglycerides and may be best used in patients for whom fasting is difficult.

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

Dr. Akta Dubey
Consultant Pathologist

Dr. Rekha Nair, MD
Microbiologist

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SECTOR 10,
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222, 022-49723322,
022-49723322



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Cert. No. MC-2275

LABORATORY REPORT

PATIENT NAME : MRS.SANGEETA GOR



PATIENT ID : **FH.3022251**

CLIENT PATIENT ID : UID:3022251

ACCESSION NO : **0022VL005461**

AGE : 57 Years SEX : Female

ABHA NO :

DRAWN : 24/12/2022 12:12:00

RECEIVED : 24/12/2022 12:12:03

REPORTED : 24/12/2022 13:28:28

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR :

CLINICAL INFORMATION :

UID:3022251 REQNO-1349081

CORP-OPD

BILLNO-150122OPCR066018

BILLNO-150122OPCR066018

Test Report Status	Final	Results	Biological Reference Interval	Units
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BIOCHEMISTRY

GLUCOSE, POST-PRANDIAL, PLASMA

PPBS(POST PRANDIAL BLOOD SUGAR)	99	70 - 139	mg/dL
---------------------------------	----	----------	-------

METHOD : HEXOKINASE

Comments

NOTE: - RECHECKED FOR POST PRANDIAL PLASMA GLUCOSE VALUES . TO BE CORRELATE WITH CLINICAL, DIETETIC AND THERAPEUTIC HISTORY.

Interpretation(s)

GLUCOSE, POST-PRANDIAL, PLASMA-High fasting glucose level in comparison to post prandial glucose level may be seen due to effect of Oral Hypoglycaemics & Insulin treatment, Renal Glycosuria, Glycaemic index & response to food consumed, Alimentary Hypoglycemia, Increased insulin response & sensitivity etc.Additional test HbA1c

****End Of Report****

Please visit www.srlworld.com for related Test Information for this accession

Dr.Akta Dubey

Consultant Pathologist

SRL Ltd
HIRANANDANI HOSPITAL-VASHI, MINI SEASHORE ROAD,
SECTOR 10,
NAVI MUMBAI, 400703
MAHARASHTRA, INDIA
Tel : 022-39199222,022-49723322,
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Patient Ref. No. 22000000817728



Cert. No. MC-2984



LABORATORY REPORT

PATIENT NAME : MRS.SANGEETA GOR

PATIENT ID : **FH.3022251**

CLIENT PATIENT ID : UID:3022251

ACCESSION NO : **0022VL005357**

AGE : 57 Years SEX : Female

ABHA NO :

DRAWN : 24/12/2022 09:10:00

RECEIVED : 24/12/2022 09:10:22

REPORTED : 24/12/2022 16:57:53

CLIENT NAME : **FORTIS VASHI-CHC -SPLZD**

REFERRING DOCTOR : SELF

CLINICAL INFORMATION :

UID:3022251 REQNO-1349081

CORP-OPD

BILLNO-150122OPCR066018

BILLNO-150122OPCR066018

Test Report Status	Final	Results	Biological Reference Interval	Units
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SPECIALISED CHEMISTRY - HORMONE

THYROID PANEL, SERUM

T3	144.5	Non-Pregnant Women 80.0 - 200.0 Pregnant Women 1st Trimester:105.0 - 230.0 2nd Trimester:129.0 - 262.0 3rd Trimester:135.0 - 262.0	ng/dL
----	-------	---	-------

METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY

T4	9.78	Non-Pregnant Women 5.10 - 14.10 Pregnant Women 1st Trimester: 7.33 - 14.80 2nd Trimester: 7.93 - 16.10 3rd Trimester: 6.95 - 15.70	µg/dL
----	------	---	-------

METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY

TSH (ULTRASENSITIVE)	3.600	0.270 - 4.200	µIU/mL
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METHOD : ELECTROCHEMILUMINESCENCE, COMPETITIVE IMMUNOASSAY

Interpretation(s)

****End Of Report****

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Dr. Swapnil Sirmukaddam
786

Dr. Swapnil Sirmukaddam
Consultant Pathologist

SRL Ltd
BHOOMI TOWER, 1ST FLOOR, HALL NO.1, PLOT NO.28 SECTOR
4, KHARGHAR
NAVI MUMBAI, 410210
MAHARASHTRA, INDIA
Tel : 91115911115,
91115911116



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Patient Ref. No. 220000008

JUZZZ51
57 Years

SANGETTA GOR
Male

12/24/2022 11:22:23 AM

HC

Rate 83 . Sinus rhythm.....normal P axis, V-rate 50- 99
 . Probable left atrial enlargement.....P >50ms, <-0.10mV V1
 . Borderline T abnormalities, diffuse leads.....T flat/seg

PR 137
 QRSD 83
 QT 333
 QTC 392

--AXIS--

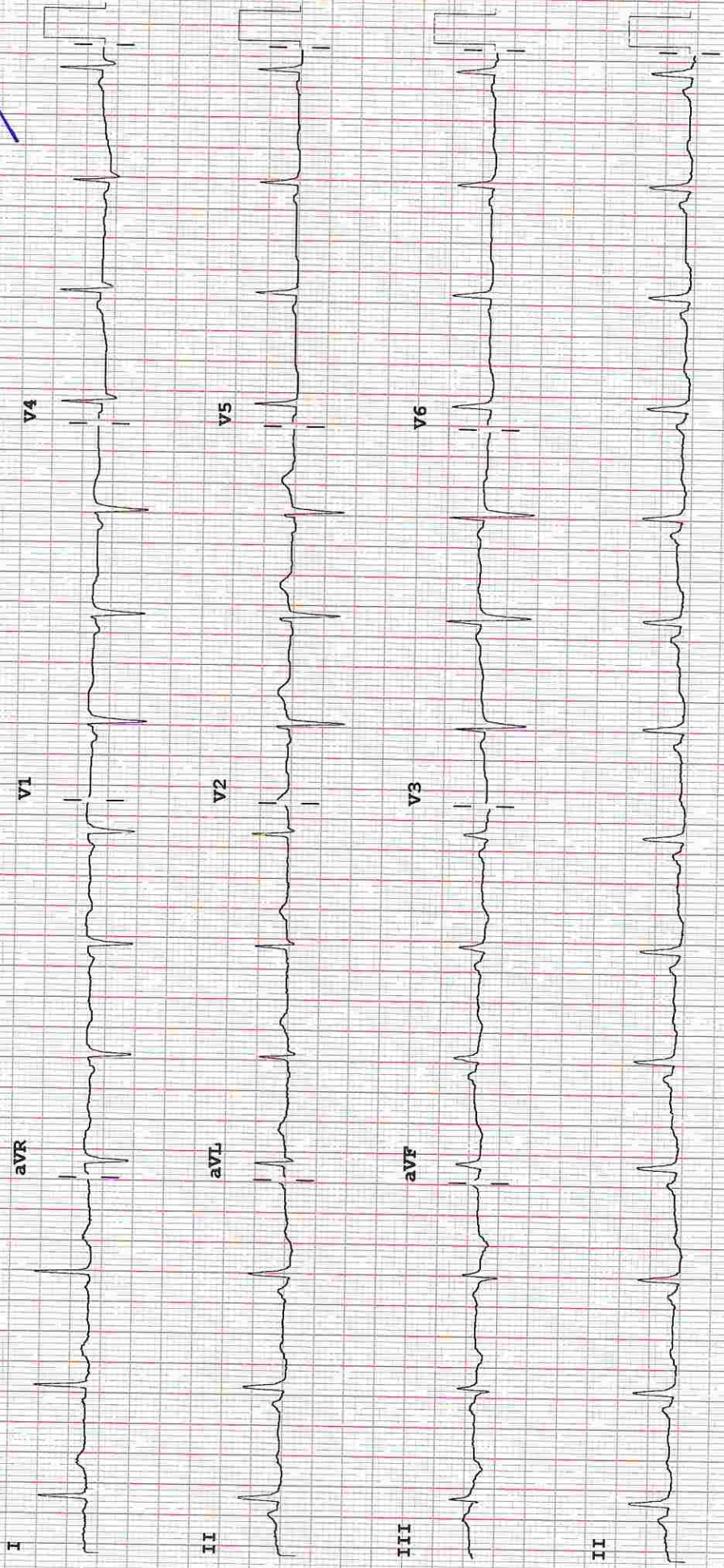
P 69
 QRS 35
 T -43

12 Lead; Standard Placement

- BORDERLINE ECG -

Unconfirmed Diagnosis

Sin rhythm in III, aVF
normal P axis
Corrected QTc 414 ECHD
Adv - 2020 ECHD
B



Device:

Speed: 25 mm/sec Limb: 10 mm/mV Chest: 10.0 mm/mV

F 50~ 0.50-100 Hz W

100B CL

P?



(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF NIC

Date: 24/Dec/2022

Name: Mrs. Sangeeta Gor
 Age | Sex: 57 YEAR(S) | Female
 Order Station : FO-OPD
 Bed Name :

UHID | Episode No : 3022251 | 65328/22/1501
 Order No | Order Date: 1501/PN/OP/2212/138911 | 24-Dec-2022
 Admitted On | Reporting Date : 24-Dec-2022 12:33:32
 Order Doctor Name : Dr.SELF .

ECHOCARDIOGRAPHY TRANSTHORACIC

FINDINGS:

- No left ventricle regional wall motion abnormality at rest.
- Normal left ventricle systolic function. LVEF = 60%.
- No left ventricle diastolic dysfunction. No e/o raised LVEDP.
- No mitral regurgitation.
- No aortic regurgitation. No aortic stenosis.
- Trivial tricuspid regurgitation. No pulmonary hypertension. PASP = 30 mm of Hg.
- Intact IVS and IAS.
- No left ventricle clot/vegetation/pericardial effusion.
- Normal right atrium and right ventricle dimension and function.
- Normal left atrium and left ventricle dimension.
- IVC measures 15 mm with normal inspiratory collapse .

M-MODE MEASUREMENTS:

LA	36	mm
AO Root	30	mm
AO CUSP SEP	20	mm
LVID (s)	25	mm
LVID (d)	37	mm
IVS (d)	08	mm
LVPW (d)	07	mm
RVID (d)	22	mm
RA	30	mm
LVEF	60	%



(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF NIC

Date: 24/Dec/2022

Name: Mrs. Sangeeta Gor

UHID | Episode No : 3022251 | 65328/22/1501

Age | Sex: 57 YEAR(S) | Female

Order No | Order Date: 1501/PN/OP/2212/138911 | 24-Dec-2022

Order Station : FO-OPD

Admitted On | Reporting Date : 24-Dec-2022 12:33:32

Bed Name :

Order Doctor Name : Dr.SELF .

DOPPLER STUDY:

E WAVE VELOCITY: 0.8 m/sec.

A WAVE VELOCITY:0.7 m/sec

E/A RATIO: 1.1

	PEAK (mmHg)	MEAN (mmHg)	V max (m/sec)	GRADE OF REGURGITATION
MITRAL VALVE	N			Nil
AORTIC VALVE	05			Nil
TRICUSPID VALVE	30			Trivial
PULMONARY VALVE	2.0			Nil

Final Impression :

- No RWMA.
- No LV diastolic dysfunction.
- Trivial TR. No PH.
- Normal LV and RV systolic function.

DR. PRASHANT PAWAR,
DNB(MED), DNB (CARDIOLOGY)



DEPARTMENT OF RADIOLOGY

Date: 24/Dec/2022

Name: Mrs. Sangeeta Gor

Age | Sex: 57 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 3022251 | 65328/22/1501

Order No | Order Date: 1501/PN/OP/2212/138911 | 24-Dec-2022

Admitted On | Reporting Date : 24-Dec-2022 18:43:13

Order Doctor Name : Dr.SELF .

X-RAY-CHEST- PA

Findings:

Both lung fields are clear.

The cardiac shadow appears within normal limits.

Trachea and major bronchi appears normal.

Both costophrenic angles are well maintained.

Bony thorax is unremarkable.

DR. YOGINI SHAH
DMRD., DNB. (Radiologist)



DEPARTMENT OF RADIOLOGY

Date: 24/Dec/2022

Name: Mrs. Sangeeta Gor

Age | Sex: 57 YEAR(S) | Female

Order Station : FO-OPD

Bed Name :

UHID | Episode No : 3022251 | 65328/22/1501

Order No | Order Date: 1501/PN/OP/2212/138911 | 24-Dec-2022

Admitted On | Reporting Date : 24-Dec-2022 14:43:18

Order Doctor Name : Dr.SELF.

US-WHOLE ABDOMEN

LIVER is normal in size (13.6) and echogenicity. No IHBR dilatation. No focal lesion is seen in liver. Portal vein appears normal in caliber.

GALL BLADDER is physiologically distended. Gall bladder reveals normal wall thickness. No evidence of calculi in gall bladder. No evidence of pericholecystic collection. **CBD** appears normal in caliber.

SPLEEN is normal in size (8.8 cm) and echogenicity.

BOTH KIDNEYS are normal in size and echogenicity. The central sinus complex is normal. No evidence of calculi/hydronephrosis. Right kidney measures 10.1 x 3.0 cm. Left kidney measures 10.7 x 4.3 cm.

PANCREAS: Head of pancreas appears unremarkable. Rest of the pancreas is obscured.

URINARY BLADDER is normal in capacity and contour. Bladder wall is normal in thickness. No evidence of intravesical calculi.

UTERUS measures 4.1 x 2.2 x 3.1 cm in size.

An heteroechoic lesion of size 2.5 x 2.0 cm is noted at the fundal region. It does not show vascularity on colour doppler evaluation. Few echogenic foci are noted within.

Endometrium measures 3.2 mm in thickness.

A heteroechoic lesion of size 2.5 x 1.6 x 2.5 cm is noted in right adnexa. Few dense echogenic foci are noted within -likely calcifications. No vascularity is noted on colour doppler evaluation.

No evidence of ascites.

IMPRESSION:

- Heteroechoic lesion at the uterine fundal region as described in text- possibility of fibroid should be considered.
 - Heteroechoic lesion with dense echogenic foci in right adnexa as described in text- dermoid should be ruled out.
- Suggest clinical correlation /follow up / further evaluation with MRI Pelvis if clinically indicated.*

DR. YOGESH PATHADE
(MD Radio-diagnosis)



(For Billing/Reports & Discharge Summary only)

DEPARTMENT OF RADIOLOGY

Date: 26/Dec/2022

Name: Mrs. Sangeeta Gor
Age | Sex: 57 YEAR(S) | Female
Order Station : FO-OPD
Bed Name :

UHID | Episode No : 3022251 | 65328/22/1501
Order No | Order Date: 1501/PN/OP/2212/138911 | 24-Dec-2022
Admitted On | Reporting Date : 26-Dec-2022 10:39:09
Order Doctor Name : Dr.SELF .

MAMMOGRAM - BOTH BREAST

Findings:

Bilateral film screen mammography was performed in cranio-caudal and medio-lateral oblique views.

Both breasts show scattered areas of fibroglandular density.

No evidence of any dominant mass, clusters of microcalcifications, nipple retraction, skin thickening or abnormal vascularity is seen in either breast.

No evidence of axillary lymphadenopathy.

IMPRESSION:

- No significant abnormality detected. (BI-RADS category I).
- No obvious mass lesion in the breasts.

Normal-interval follow-up is recommended.

DR. YOGINI SHAH
DMRD., DNB. (Radiologist)